HEALTH INTAKE FORM: NEW CHOLESTEROL PATIENT

Date: ________
Patient Name: _________________________

Welcome to Capital District Pediatric Cardiology. Please take a few minutes to answer some background health questions regarding your/your child's patient visit with us today. Answer as best as you can on both the front and back of this sheet. If more space is needed, please feel free to use the space on the back side of this sheet. Your doctor will go over everything with you during your visit, and answer all of your questions. PLEASE RETURN THIS FORM TO THE FRONT DESK PRIOR TO YOUR VISIT. Thanks!

Reason/Main Concern For Your Visit Today: ______________________

Specialist Physicians (other than the Primary Physician) Caring for the Patient:

1)_____________ 2)_____________ 3)_____________

Patient's Current Medications:

Medication Name	Dose/Amount	Frequency/times per day
1)____________	___________	____________________
2)____________	___________	____________________
3)____________	___________	____________________

Patient's Allergies to Any Medications:

Medication Name:	If allergic, type of reaction
1)____________	_____________________
2)____________	_____________________

Pharmacy Preferred For Prescriptions:

Name: ______________________
Address (or location): ______________________
City: ______
State: ______
Phone: ______________________

Patient's Past History of:

Surgeries (Type and Date)	Hospitalizations Overnight (Reason and Date)
_____________________	____________________________________
_____________________	____________________________________
_____________________	____________________________________
_____________________	____________________________________

Family History:

Any parent, sibling, grandparent or aunt/uncle:

born with a congenital heart defect? Yes No
with a history of an irregular or abnormal heart rhythm? Yes No

Any parent, sibling, grandparent or aunt/uncle:

With a heart attack, treated chest pain, coronary stent placement, coronary bypass surgery, stroke or sudden death before the age of 55 years in males or 65 years in females? Yes No

Patient Review of Systems:

Any current symptoms with (if yes, circle the specific symptom):

Systemic: such as fever, weight gain/loss, loss of appetite	Yes	No
Head: such as headaches, sinus pain	Yes	No
Neck: such as pain, stiffness, swollen glands	Yes	No
Eyes: such as with vision, redness, pain, swelling	Yes	No
ENT: such as speech, nasal, hearing, swallowing trouble	Yes	No
Dental: such as with teeth, gums	Yes	No
Heart: your doctor will ask you about this directly		
Lungs: such as cough, wheeze, phlegm, shortness of breath	Yes	No
Abdomen: such as vomiting, diarrhea, pain, swelling	Yes	No
Kidneys: such as bloody, frequent or painful urination	Yes	No
Endocrine: such as thirst, temperature sensitivity, hair loss	Yes	No
Blood problems: such as anemia, bleeding	Yes	No
Muscle and Joints: such as swelling, pain, weakness	Yes	No
Neurologic: such as developmental delay, seizure, migraine	Yes	No
Skin: such as rashes, sores, blueness	Yes	No
Allergy/Immunity: such as chronic infections, allergies	Yes	No
Psychosocial: such as school problems, behavior problems	Yes	No

Risk Factors:

Does the patient have a history of:

Smoking	Yes	No
Hypertension	Yes	No
Diabetes	Yes	No
Chronic kidney disease	Yes	No
Heart transplant	Yes	No
Kawasaki's disease	Yes	No
Lupus or juvenile rheumatic arthritis	Yes	No
Nephrotic syndrome	Yes	No

Has the patient been seen by a dietician? Yes No

Are there any other concerns or questions for today's visit?

Please use the space below for any additional information.

PLEASE RETURN THIS FORM TO THE RECEPTIONIST AT THE FRONT DESK (EVEN IF NOT COMPLETED) PRIOR TO YOUR VISIT.